

Case Number:	CM14-0140117		
Date Assigned:	09/08/2014	Date of Injury:	02/19/2008
Decision Date:	10/10/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	08/29/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 69-year-old female who reported an injury on 02/19/2008 due to a lifting injury. On 07/24/2014 the injured worker presented with right shoulder pain. She also reported constant pain in the lower back. Upon examination there was nonspecific tenderness to palpation to the right shoulder and moderate tenderness at the supraspinatus and infraspinatus to the right. The range of motion values on all shoulders were 160 degrees of flexion, 40 degrees of extension, 160 degrees of abduction, 40 degrees of adduction, 80 degrees of internal rotation and 80 degrees external rotation. Examination of the lumbar spine revealed a positive iliac compression, Kemp's and Lasegue's test, a positive bilateral straight leg raise and moderate paraspinals tenderness from L4-5, L5-S1. Diagnoses were radiculitis lumbosacral, lumbar spine disc disease and right shoulder impingement syndrome. Prior therapies were not provided. The provider recommended shockwave therapy, TENS unit, Tramadol and Flurbiprofen. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Shockwave Therapy (right shoulder) #3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute (ODG) Guidelines-Shoulder (Acute & Chronic) updated 7/29/14

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: The request for Shockwave Therapy (right shoulder) #3 is not medically necessary. The California MTUS/ACOEM Guidelines note some medium quality evidence support manual physical therapy, ultrasound and high energy extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. Initial use of less invasive techniques provide an opportunity for clinicians to monitor progress before referral to a specialist. There is lack of information in the physical exam and lack of documentation of other treatments the injured worker underwent previously or the measurement of progress with the prior treatments. The documentation provided is unclear as to how the electroshockwave therapy will provide the injured worker with functional improvement. The provider's rationale was not provided. As such, medical necessity has not been established.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic Pain (Transcutaneous Electrical Nerve Stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENs Page(s): 116.

Decision rationale: The request for a TENS unit is not medically necessary. The California MTUS does not recommend a TENS unit as a primary treatment modality. Even with home base, TENS should only be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration. The results of studies are inconclusive and the published trials have not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long term effectiveness. There is a lack of documentation indicating significant deficits upon physical examination. The efficacy of the prior courses of conservative treatment were not provided. It was unclear if the injured worker underwent an adequate TENS trial. The request is also unclear as to whether the injured worker needed to rent or purchase a TENS unit. The body part at which the TENS unit is indicated for is not provided in the request as submitted. As such, medical necessity has not been established.

Tramadol 8% Gabapentin 10% Menthol2%, Camphor 2% #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The request for Tramadol 8% Gabapentin 10% Menthol2%, Camphor 2% #1 is not medically necessary. The California MTUS Guidelines state that transdermal

compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. Any compounded product that contain at least 1 drug that is not recommended, is not recommended. The guidelines note that muscle relaxants are not recommended for topical applications. Many agents are compounded as monotherapy in combination for pain control including NSAIDs, opioids, capsaicin, antidepressants, prostanoids, biogenic amines, and nerve growth factor. There is little to no research to support the use of many of these agents. The provider does not indicate the site at which the medication was intended for, the frequency or the quantity in the request as submitted. As such, medical necessity has not been established.

Flurbiprofen 20% #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The request for Flurbiprofen 20% #1 is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contain at least 1 drug that is not recommended, is not recommended. The guidelines note that NSAIDs are recommended for osteoarthritis and tendinitis or other joints amenable to topical treatment. It is recommended for short term use. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis at the spine, hip or shoulder. The injured worker's diagnosis is not congruent with the guideline recommendations for topical NSAIDs. Additionally, the provider does not indicate the site at which the cream is indicated for, or the frequency in the request as submitted. As such, medical necessity has not been established.